STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRY
Drawer 20
Montpelier, VT 05620-3401

Form 1 (Rev. 1/02)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYEE'S CLAIM AND EMPLOYER FIRST REPORT OF INJURY

Complete form in ink or typewriter and send original to the Commissioner of Labor and Industry within 72 hours of accident. Send duplicate to your workers' compensation insurance company, give Employee's copy to employee and retain Employer's copy for your files. Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee's Social Security Number MUST be provided.

EMPLOYER

1.Legal Name:	2.Business Name:	
3. Mail Address: No. and Street / City / State / Zip		
4. Location (if different from Mail Address):		Federal ID No.
5. Nature of Business (list principal products or service of concern):	Do you regularly employ 10 or more employees? ☐ Yes ☐ No	Telephone No.

EMPLOYEE

6. Name: First Name / Middle Initial / Last Name		8. Social Security No.	9. Date of birth:
7. Home Address: No. and Street	Telephone No.	10. Job Title:	9A. Age
City or Town / State / Zip		12. Dept. assigned to:	11. Sex ☐ M ☐ F

13. Wages $ Per	Hours Per Day / Days Per Week	14. If board, lodging, etc. were furnished in addition to wages, state estimated value: $	15. Was employee hired in VT? ☐ No ☐ Yes	16. Date of Hire

ACCIDENT

17. Date of Accident:	Accident Time a.m. p.m.	Began Shift a.m. p.m.	20.Machine or tool involved in the accident:
18. Location of Accident: Town or City / State			21. Was it defective? ☐ No ☐ Yes If yes, describe how.
19.On employer's premises? ☐ No ☐ Yes If yes, name of dept.:			22.Object or substance directly causing injury:
23. Describe what employee was doing:			Was this the employee's regular occupation? ☐ No ☐ Yes
24.How did accident occur? Describe events leading up to the accident.			
25.Can the employer prevent this type of accident? ☐ No ☐ Yes If yes, describe how.			
26. Was safety equipment, such as goggles or guards, etc. provided? ☐ No ☐ Yes			
27. Could the injured have prevented this type of accident? ☐ No ☐ Yes If yes, describe how (do not say, "By being more careful.").			
28. If safety equipment was provided, was it being used? ☐ No ☐ Yes			

INJURY

29. Describe the injury and the part of body injured.					
30. Any Lost Time? ☐ No ☐ Yes	If yes, date disability began.	Last date paid in full:	31. Employee returned to work? ☐ No ☐ Yes	If yes, date returned.	At what weekly wage: $
32.Did injury result in death? ☐ No ☐ Yes	If yes, date of death.	33. If death, name and address of nearest relative.			Relationship
34. Name and Address of Physician					
35. Name and Address of Hospital				Remained overnight? Yes ☐ No ☐	

INS

36.Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name.	
Name in full:	Policy No.
Signed by:	
Employer or Representative / Title / Date	

____Provided Form 8 ____ Labor & Industry ____ Ins. Co. ____Employer ____Employee